FULLER HOSPITAL
LEADING THE WAY IN BEHAVIORAL HEALTH

PARTIAL HOSPITALIZATION PROGRAM (PHP) & INTENSIVE OUTPATIENT PROGRAM (IOP)

REFERRAL FORM FOR ADULT COMMUTER

FAX: 508-838-2326 **PHONE:** 508-838-2337 **EMAIL:** FULLERPARTIALPROGRAM@UHSINC.COM

- **Partial Hospital Program (PHP):** a short term (2+ weeks) intensive group therapy program which runs Monday- Friday from 9am to 2pm; **either in-person** or **online via Telehealth** with lunch from 12PM to 1PM.
- **Intensive Outpatient Program (IOP):** half day programming which allowing ability to maintain responsibilities while also receiving intensive group therapy. IOP runs Monday-Friday; 3-5 days per week from either 9AM to 12PM or 5PM to 8PM
- **In-Person** participants will attend groups and meet with a clinician and provider during that time. Intake appointments are at 9am and patients should plan on staying for their first full day after intake.
- **Telehealth** allows individuals to get the services they need in the comfort of their home; sessions are not a recording or webinar, instead it is a session in real time, with real people.

THIS REFERRAL IS BEING MADE FOR TREATMENT IN THE FOLLOWING PROGRAM: (please check one)

☐ **In-Person** Partial Hospitalization Program (PHP) ☐ **Tele-health (online & in real time)** Partial Hospitalization Program (PHP)
☐ **In-Person** Intensive Outpatient Program (IOP) ☐ **Tele-health (online & in real time)** Intensive Outpatient Program (IOP)

DEMOGRAPHIC INFORMATION			
Patient's Name:		Referral Date:	
DOB:	Last 4 #s of SSN:	Gender:	
Primary Language:		Marital Status:	
Address:	City:		Zip:
Phone:	Email:		

INSURANCE INFORMATION	
Primary Insurance:	Policy #:
Subscriber Name:	Relation/DOB:
Secondary Insurance:	Policy #:
Subscriber Name:	Relation/DOB:

CLINICAL INFORMATION	
Presenting Problem(s):	
Current Diagnoses if known (please include DSM-V ICD-10 Code): Psychiatric Dx: Medical Dx:	
Psychosocial Stressors: ☐ Primary Support Group ☐ Social Environment ☐ Educational ☐ Occupational ☐ Housing ☐ Economic ☐ Legal ☐ Access to Health Care ☐ Other:	
Ever been diagnosed with an eating disorder? ☐ Yes ☐ No	If Yes, last active time frame:
Accommodations Needed:	
Any Cognitive/Intellectual Disabilities?	
Is this a step down from inpatient? ☐ Yes ☐ No	If Yes, Discharge Date:

REFERRAL SOURCE INFORMATION	
Name of referring agency/facility:	
How did you hear about Fuller PHP?	
Contact Person:	Phone number:
Email address:	Date of Referral:

INTAKE OFFICE USE ONLY	
Call entered into MS4? ☐ **Yes** ☐ **No**	**Date/Person:**
Intake Appointment Scheduled ☐ **Yes** ☐**No**	☐ **Telehealth** ☐ **In-Person**
Date of intake:	☐ **9am** ☐ **10am** ☐ **12pm** ☐ **1pm** ☐ _____
Reminder Calls ☐ 1st ☐ 2nd ☐ 3rd	**Phone number:**